

November 1991

MEDICARE

HCFA Needs to Take Stronger Actions Against HMOs Violating Federal Standards



Human Resources Division

B-243161

November 12, 1991

The Honorable Fortney H. (Pete) Stark
Chairman, Subcommittee on Health
Committee on Ways and Means
House of Representatives

The Honorable Lawrence J. Smith
House of Representatives

The Honorable E. Clay Shaw
House of Representatives

Over the past decade, the Health Care Financing Administration (HCFA) has encouraged Medicare beneficiaries to enroll in health maintenance organizations (HMOs). HMOs are attractive because they have financial incentives to control costs and utilization and offer beneficiaries more services than are normally covered under Medicare. However, a series of GAO reports, issued over the past 5 years (see p. 32), has highlighted persistent problems with some HMOs' compliance with Medicare requirements and with the adequacy of federal oversight.¹

Recently, concerns over federal HMO oversight were rekindled by press articles alleging widespread compliance problems with Medicare's largest HMO contractor—the Humana Medical Plan, Inc. (HMP), in Florida.² The articles reported instances of marketing and claims payment abuses by HMP as well as problems relating to its quality of care.³ Because of the significance of the allegations and the history of problems of this HMO under its previous owner, you requested that we assess federal oversight of HMP. Specifically, you asked that we ascertain whether HCFA, which administers Medicare for the Department of Health and Human Services (HHS), had identified the problems alleged by the press and whether HCFA's actions to resolve problems at HMP were prompt and effective. To do so, we reviewed the chronology of events regarding HCFA's monitoring of HMP's compliance with federal requirements.

¹We have used the terms compliance and noncompliance throughout this report to indicate conformity with or a violation of Medicare's requirements. These terms also have a technical meaning under title 13 of the Public Health Service Act, which governs federal qualification of HMOs. We have not used the terms in this technical sense.

²HMP is owned by Humana, Inc. In this report, "Humana" refers to the parent corporation.

³"Risky Rx: The Gold Plus Plan for the Elderly," Sun-Sentinel (Fort Lauderdale, Fla., Oct. 21-24, 1990).

Results in Brief

The HMP case illustrates, as did our earlier work, that HCFA has not been effective in achieving prompt corrective actions from some noncompliant HMOs. HCFA can and should have done more to require that HMP resolve its deficiencies.

Through a series of site visits and investigations at HMP beginning in February 1989, HCFA found not only those problems that have been identified in the press, but additional problems as well. Specifically, HCFA found HMP to be in violation of federal standards related to four areas: marketing, claims payment, processing beneficiary appeals, and implementing an internal quality assurance system.

Problems of the nature HCFA identified at HMP can have significant adverse effects on beneficiaries' out-of-pocket costs and on their access to, and quality of, care. To the extent that HMOs do not adhere to federal requirements relating to marketing, misinformed beneficiaries can incur high costs by mistakenly obtaining unauthorized services for which they are liable. Further, for HMOs that do not promptly pay or that inappropriately deny payment for bills for authorized services, Medicare enrollees can and do receive actions by bill collectors, though the enrollees are not legally liable for paying these bills. And beneficiaries in HMOs that do not follow prescribed claims appeal processes or quality assurance systems may not receive the services or quality they are entitled to under the HMOs' Medicare contracts.

Although HCFA repeatedly requested HMP to resolve its deficiencies, as of October 1991, HMP remained out of compliance in two of the four problem areas—claims payment and beneficiary appeals. Earlier, in a 1988 report, we noted that HCFA failed to gain prompt resolution of the compliance deficiencies of some HMOs, raising issues of HCFA's ability and willingness to enforce Medicare standards.⁴ The HMP situation provides evidence that these issues have not yet been resolved.

Allowing HMP to enroll over 125,000 new beneficiaries during its protracted period of noncompliance was unreasonable. HCFA has the authority to have imposed sanctions against the HMO by suspending its right to continue enrolling Medicare beneficiaries. HCFA, however, felt constrained in doing so because it had not issued regulations implementing this authority—though almost 4 years have passed since the authority was granted. To help prevent the recurrence of problems like

⁴Medicare: Experience Shows Ways to Improve Oversight of Health Maintenance Organizations (GAO/HRD-88-73, Aug. 1988).

those with HMP, HCFA needs to unequivocally establish both its authority and intention to take timely and decisive action against HMOs that violate Medicare's minimum beneficiary safeguard standards. HCFA can do so by finalizing its sanction regulations, devising and publishing standards necessary to enforce its requirements, and developing policies concerning when it will stop requesting compliance and begin imposing a sanction.

Background

Medicare's Risk HMOs

The Medicare program, authorized by title 18 of the Social Security Act, is a health insurance program available to most people 65 years of age and older and to some of the disabled. Although most of the 33 million Medicare beneficiaries receive their health care from fee-for-service providers, about 1.4 million have opted to receive care from HMOs participating in Medicare's risk-contract HMO program. Under a risk contract, the HMO provides all necessary medical care in return for a predetermined monthly payment from Medicare for each enrolled beneficiary. Within certain limits, risk HMOs can profit if their cost of providing services is less than the predetermined payment, but the HMOs run the risk of a loss should their cost be higher.

The Social Security Act and the Public Health Service Act impose standards designed to protect Medicare beneficiaries in risk HMOs. These standards relate to such matters as HMO management, quality assurance, membership requirements, and financial solvency. In addition, since April 1987, HCFA's peer review organizations (PROs) have reviewed the quality of care provided Medicare beneficiaries in HMOs with Medicare risk contracts.

Until March 1991, HCFA's Office of Prepaid Health Care had overall responsibility for administering the risk HMO program.⁵ This office was assisted by HCFA's regional offices, which shared with it the responsibility for monitoring HMOs' compliance with federal requirements. HCFA makes monitoring site visits to risk HMOs, visiting, at least annually, those believed to be experiencing serious problems. During these visits, HCFA assesses compliance with Medicare requirements in nine major

⁵In March 1991, HCFA restructured its HMO program oversight (see footnote 24, p. 15).

areas, including the four—marketing, claims payment, processing beneficiary appeals, and implementing a quality assurance system—addressed in this report. After each visit, HCFA issues a site visit report, notifying the HMO of its findings and requesting a corrective action plan for deficiencies. If the HMO does not carry out corrective actions as required by HCFA, the HCFA Administrator can revoke the HMO's Medicare contract or, in some cases, suspend enrollment of additional Medicare beneficiaries or impose monetary penalties.

HMP—Largest Medicare Enrollment

HMP came into existence in June 1987 when its parent company, Humana, Inc., purchased International Medical Centers, Inc., an insolvent Florida HMO.⁶ HMP operates in four Florida markets under one contract with HCFA: Miami, Tampa, Orlando, and Daytona.⁷ With about 203,000 Medicare beneficiaries enrolled, HMP has by far the largest Medicare enrollment of any HMO, with 15 percent of all the Medicare beneficiaries enrolled in risk HMOs nationwide.⁸

The Miami and Tampa market areas account for about 84 percent of HMP's Medicare enrollment. In these two markets, as of March 1991, HMP had 240 medical centers staffed with 421 physicians available to serve Medicare enrollees.⁹ Most HMP centers, called affiliated providers, are owned and operated by group practices or individual physicians under contract with HMP. Under their contracts, affiliated providers are paid a predetermined amount per enrollee to provide health services.

In October 1990, the Fort Lauderdale Sun-Sentinel published a series of articles alleging widespread abuses against Medicare beneficiaries enrolled in HMP. These alleged abuses included improper marketing and claims payment practices as well as instances of poor quality care. The newspaper also accused the federal government of failing to act quickly to protect beneficiaries against these abuses.

⁶Humana, Inc., also owns other affiliates that have five Medicare risk contracts serving beneficiaries in seven states. These five plans, which are much smaller than HMP, together enroll about 31,000 Medicare beneficiaries.

⁷The Miami market includes Dade, Broward, and Palm Beach counties. The Tampa market includes Pasco, Pinellas, and Hillsborough counties. The Orlando market—added to Humana's contract in August 1989—includes Seminole, Osceola, and Orange counties. The Daytona market—added to Humana's contract in March 1988—includes Volusia County.

⁸As of October 1, 1991.

⁹HMP had an additional 79 centers in its Orlando and Daytona market areas. We excluded pediatric centers from all counts.

Scope and Methodology

To determine whether HCFA had identified the problems alleged in the Sun-Sentinel articles and whether HCFA's actions to resolve problems were prompt and effective, we reviewed HCFA's oversight activities for HMP since June 1987. Our work was carried out at HCFA's headquarters in Washington, D.C., and Baltimore and at its Atlanta Regional Office. In addition to interviewing HCFA officials and reviewing documents related to oversight activities, we analyzed HCFA data on enrollee complaints and on Medicare enrollments in HMOS.

We focused our work on HMP's operations in the Miami and Tampa market areas, which account for about 84 percent of HMP's Medicare enrollment. Because the press accounts alleged problems with quality of care, we interviewed Florida PRO officials and reviewed documents related to their evaluation of HMP's quality of care. We visited HMP's main office in Miami, where we interviewed HMP and parent company officials and reviewed pertinent documents. However, we did not attempt to independently verify the accuracy of HCFA's findings regarding deficiencies at HMP.

Our work was done between December 1990 and September 1991 in accordance with generally accepted government auditing standards.

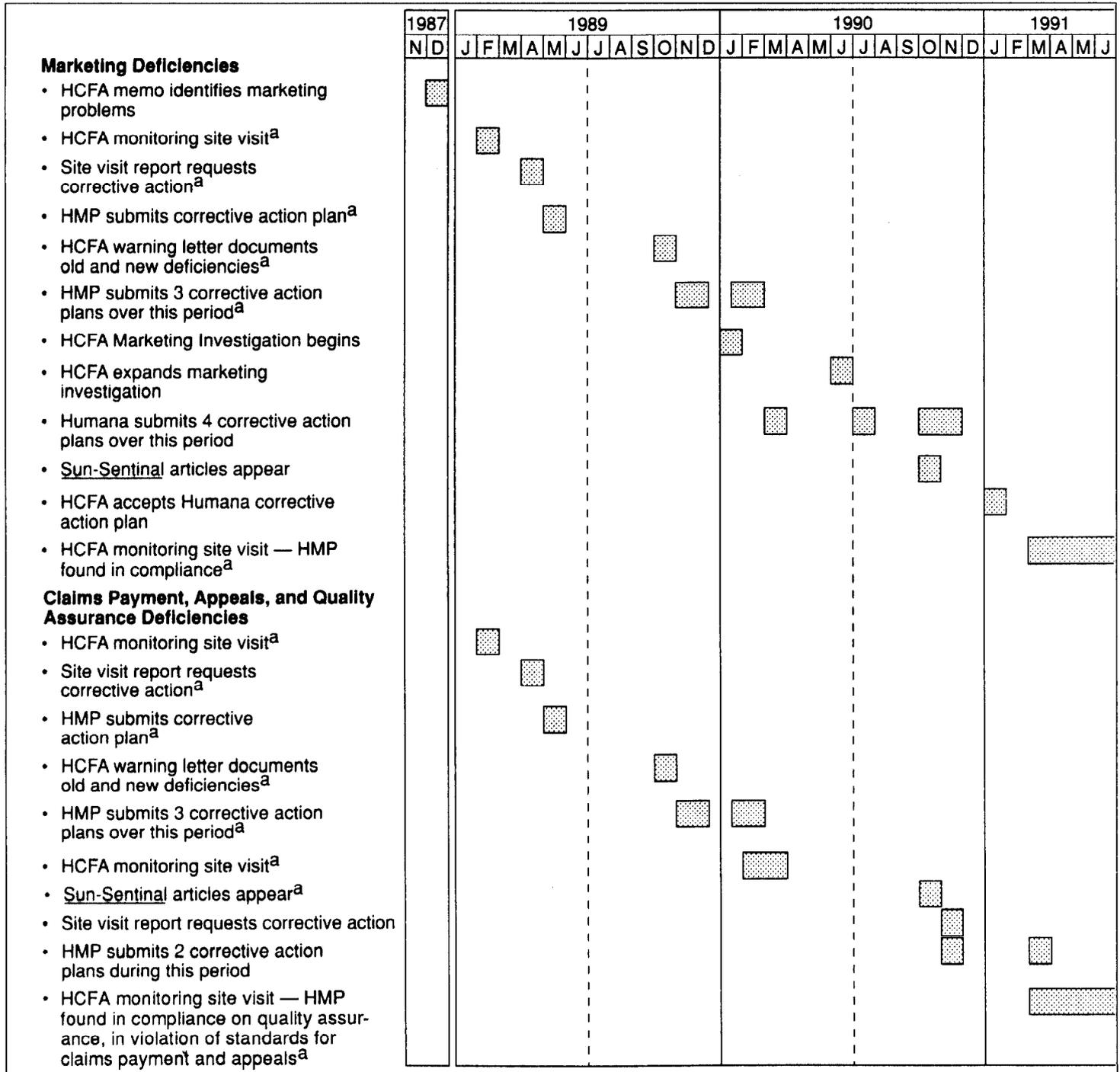
HCFA Displays Pattern of Ineffective Oversight

Through 1989 and much of 1990, HCFA's efforts to get HMP to resolve its deficiencies displayed a pattern of extensive but ineffective activity. Much of HCFA's activity did little more than document HMP's problems, and, while improvements have occurred, HCFA's 1991 monitoring visit found HMP still in violation of Medicare's requirements for two of four major areas. Recurrence of this pattern of ineffective HCFA activity, first noted in our 1988 report,¹⁰ as well as a long delay in issuing the 1990 monitoring report, indicates the persistence of problems with HCFA's program oversight of risk HMOS.

The chronology of major events relating to HCFA oversight shown in figure 1 illustrates this pattern.

¹⁰Medicare (GAO/HRD-88-73).

Figure 1: Chronology of Major Events



^aThis event is common to both categories and is therefore listed in both.

From 1989 to June 1991, HCFA made three annual monitoring visits to the site,¹¹ issued two site visit reports and one warning letter requesting corrective actions, and elicited from HMP 10 corrective action plans. Despite this activity, after 31 months, HCFA has been unable to get HMP to correct violations for two of the four major areas of deficiency—Medicare claims payment and Medicare appeals. The remaining areas—marketing and quality assurance implementation—were reported to be in compliance in HCFA's October 1991 site visit report.

HCFA's failure to get HMP to correct deficiencies in the areas of claims payment and beneficiary appeals may be partially attributed to its failure to promptly issue the report on its 1990 site monitoring visit. As can be seen in figure 1, there was an 8-month gap between the visit in March 1990 and issuance of the report in November 1990. This delay occurred at HCFA's Office of Prepaid Health Care because the office's resources were diverted to an ongoing marketing investigation of Humana. HCFA region IV officials, who shared responsibility for monitoring HMP, protested this delay. In an August 1990 internal memo, a regional official advised HCFA that the delay was hampering its efforts to obtain compliance by HMP.

Marketing Practices Remained HCFA Concern for 4 Years

Although it first expressed concerns about marketing abuses in 1987, HCFA did not cite HMP as being in violation of requirements in this area until 1989. In an internal memorandum of December 1987, HCFA officials reported that complaint and enrollment information indicated that HMP, along with other Florida HMOs, was engaging in aggressive marketing activities. These activities resulted in some beneficiaries being enrolled without their knowledge or without understanding the requirements of HMO membership.¹² Despite this, HCFA's 1988 monitoring report did not cite HMP as violating Medicare marketing standards, although HCFA did recommend that HMP monitor this area carefully to prevent future problems. HCFA officials told us that they initially chose not to emphasize compliance issues in order to give Humana time to resolve the problems acquired when it purchased the plan in June 1987.

¹¹HCFA's 1991 site visit to HMP's geographical markets was conducted in stages between March and June 1991.

¹²Medicare requires HMOs to fully inform applicants of the obligations of HMO membership. Medicare beneficiaries who enroll in risk HMOs assume the obligation of obtaining their health care services only through plan providers. Neither Medicare nor the HMO is responsible for payment for services from nonplan providers that are unauthorized by the HMO. This is generally referred to as the lock-in provision. The exceptions to this rule are emergency services obtained anywhere and urgently needed services obtained while the enrollee is outside the plan's service area.

As a result, HCFA did not cite HMP for violations in any area until the April 1989 monitoring report. At that time, it cited HMP for violating a marketing requirement that it provide members with current information on the plan's rules, benefits, and costs.

HMP continued to be out of compliance in its marketing practices. In an October 1989 warning letter and again in its 1990 monitoring site visit, HCFA found that HMP was not providing current and prospective enrollees with up-to-date information on the plan's benefits and requirements.

Meanwhile, in early 1990, marketing practices at another HMO owned by Humana led HCFA to begin an investigation into the marketing practices at five of the six Medicare prepaid health plans owned by Humana, including HMP.¹³ During this investigation, HCFA found a corporate philosophy of aggressive marketing using manipulative tactics. This philosophy was expressed most explicitly in Humana's corporate marketing training manual, which recommended, for example, that marketing agents employ a tactic called the "kleenex close." Using this tactic, a marketing agent who fails to make a sale explains, on leaving, to the customer, that this is how the agent earns a living and that the agent has obviously made a mistake. The agent then asks the customer to explain what information was not properly covered so that the agent will not repeat the mistake in the future. The agent is then advised to ". . . cover it and close [the sale]." HCFA requested that Humana revise its marketing guidance to eliminate these practices.

Inappropriate marketing practices can cause serious problems for beneficiaries who enroll without clearly understanding their obligations as HMO members. For example, in April 1990 an HMP sales representative enrolled a beneficiary, previously diagnosed as having Alzheimer's disease, whom the family did not consider competent to make such a decision. As is standard practice, HMP's enrollment department called this beneficiary and verified her intent to enroll and her understanding of plan provisions. The next month, she moved from Florida and subsequently incurred about \$3,000 in medical bills. HMP refused to pay most of this, leaving her potentially liable for over \$2,000. After correspondence with the beneficiary's family and HMP, HCFA decided to hold

¹³HCFA's Dallas regional office began the investigation when an unusually large number of Medicare enrollees requested disenrollment from the Humana Health Plan of Texas in San Antonio. HCFA found that some had been enrolled without understanding the requirements of HMO membership and others had been enrolled without their knowledge. This investigation was conducted under title 13 of the Public Health Service Act, which governs federal qualification of HMOs. It could lead to loss of federal qualification, which would automatically mean loss of Humana's Medicare contracts.

neither HMP nor the beneficiary responsible for the bills. HCFA disenrolled the beneficiary from HMP retroactive to the date of enrollment and instructed Medicare's fiscal agents to pay the bills as though the beneficiary had never been a member of HMP.¹⁴

In January 1991, HCFA approved Humana's plan for correcting its marketing deficiencies. In August 1991, HCFA terminated the Humana marketing investigation and in October reported that HMP was in compliance in this area.

During the 27-month period between HCFA's first request for corrective action in April 1989 and July 1991, HMP enrolled more than 125,000 new Medicare beneficiaries. Given the extent of its marketing problems, we believe HMP should not have been allowed to continue to enroll beneficiaries during the 27-month period when its marketing program was found to be deficient.¹⁵ While HCFA does not have legislative authority to suspend an HMO's right to continue to enroll Medicare beneficiaries because of marketing abuses, other than for misrepresentation of information (discussed more fully on p. 14), it does have authority to impose such a sanction based on other compliance problems HMP was having at the same time.

HCFA Identified Recurring Problems With Payment of Claims

HCFA found that HMP denied some claims for inappropriate reasons and that some providers with HMP contracts (called affiliated providers) did not pay claims for services performed by noncontracting providers within the required time.¹⁶ Beneficiaries may be inappropriately billed as a result of such problems.

In 1989 and again in 1990, HCFA found that HMP denied certain types of claims for inappropriate reasons. HMP refused to pay claims for emergency and urgently needed services obtained outside the HMP service

¹⁴HCFA regional office officials referred this case to the HHS Office of Inspector General and the Florida Department of Insurance for investigation as a potentially fraudulent or inappropriate enrollment.

¹⁵HCFA continued to permit new HMP enrollments during its marketing investigation, but HCFA told Humana that it would not process applications for new risk contracts or expansions of old ones. Nonetheless, HCFA did approve Humana's entry into a new market. Specifically, it approved Humana's acquisition of an HMO with an existing Medicare contract outside Florida.

¹⁶Some HMP affiliated providers' contracts permit them to pay directly claims from noncontracting providers to which the affiliated providers have referred beneficiaries for physician and other ambulatory services. HMP officials told us that they intend to phase out this practice and will eventually pay all such claims from a central location.

area that it had not authorized in advance. Denying payment for such claims is a violation of Medicare regulations that require risk HMOs to pay for services that meet Medicare's criteria for emergency or urgently needed services. Inappropriate denials can result in providers' attempts to collect the amounts due from beneficiaries. Nevertheless, during the 1990 site visit, HCFA found that 40 percent of a sample of 30 denied claims were emergency or urgently needed care claims that HMP had denied for lack of advance authorization.

Denying payment for inappropriate reasons can potentially cause problems for beneficiaries, who may receive large bills when both HMP and Medicare refuse to pay. For example, in December 1989, an HMP Medicare enrollee was admitted to a hospital on an emergency basis with severe pneumonia. On the grounds that an HMP physician had not authorized this admission, HMP refused to pay for it. This left the beneficiary with an unpaid \$24,000 hospital bill. Eventually, the hospital asked HCFA to intervene and, in April 1991, 16 months after the beneficiary was discharged, HMP reversed its position and paid for the admission.

In addition, in both 1989 and 1990, HCFA found that HMP's affiliated providers did not pay claims within the time frames that Medicare required. In 1990, for a sample of 30 claims paid by affiliated providers in Tampa, the average processing time was 47 days from receipt to payment, as compared with a required 25 or 24 days.¹⁷ From another sample of 30 claims paid by affiliated providers in Miami, HCFA was unable to determine the processing time for 27 because they either did not show the date the affiliated provider received the claim or showed the date in pencil, which HCFA considered unreliable. However, HCFA noted that only 6 had been paid within 90 days of the date the service had been rendered, and the average elapsed time between the dates of service and payment was 131 days.

During its 1991 site visit to HMP, HCFA found that HMP's affiliated providers in its Miami market areas were still not paying claims accurately or in a timely manner. Out of a sample of 30 claims denied by affiliated providers, HCFA found that 3 had been denied inappropriately. In all 3 cases, an affiliated provider denied payment for physician services provided during an out-of-plan emergency hospital stay despite the fact that payment for the stay had already been approved by HMP's claims

¹⁷The Omnibus Budget Reconciliation Act of 1986 required HMOs to pay such claims within 26 days in fiscal year 1988, 25 days in fiscal year 1989, and 24 days in fiscal year 1990 and thereafter.

payment center, which pays all hospital claims. In addition, HCFA found that a significant percentage of its samples of affiliated provider-paid claims were not being paid within the required time frame. HCFA cited HMP for violating claims payment timeliness standards but did not cite HMP for its accuracy problems. As discussed more fully later (see p. 16), HCFA has no HMO standards for determining the accuracy of claims payment determinations. Therefore, it had no basis on which to make a determination of compliance.

HMP Continues to Violate Standards in Handling Beneficiaries' Appeals

Medicare enrollees have the right to appeal a risk HMO's refusal to furnish or pay for services covered under the HMO's Medicare contract. Medicare regulations set forth specific criteria and time frames that the HMO must meet for handling appeals. The regulations also require an HMO to send a case not resolved in the beneficiary's favor to HCFA for a final adjudication. HCFA found that HMP did not follow these regulations. Specifically, HMP did not always treat beneficiary complaints about denial of, or payment for, services as Medicare appeals, thus denying beneficiaries their appeal rights. Further, when HMP did properly classify appeal cases, it often did not meet required time frames for resolving the cases.

In its 1989 site visit, HCFA found that HMP did not clearly distinguish between the Medicare appeals process and its regular grievance process for handling other types of complaints. As a result, HMP handled as ordinary grievances certain complaints that should have been handled as Medicare appeals. In addition, HMP did not meet the required 60-day time frame for processing any of a sample of 14 cases that it had treated as Medicare appeals. HCFA officials found similar problems during their 1990 and 1991 site visits. In its 1991 site visit to the Miami market area, HCFA found that out of 60 grievances reviewed, 31 should have been handled as Medicare appeals.

HMP's Medicare appeals deficiency is of particular concern in light of HMP's deficiencies in claims payment discussed above. Beneficiaries whose claims for emergency or urgently needed care are inappropriately denied on the grounds that they are unauthorized may also find that the process intended to provide for HCFA to reconsider and ultimately adjudicate such denials is not available to them. Such beneficiaries may find themselves liable for large medical bills with little recourse except the courts, which many may find too costly and unfamiliar to use. HCFA's 1991 site visit report specifically notes the similarity of deficiencies in this area to those found in 1989.

HCFA Aware of Persistent Problems With Quality Assurance

In 1989 and 1990, HCFA found HMP to have an inadequate quality assurance program. Furthermore, HMP and the Florida PRO both found instances of poor quality care. Although found to be in compliance in this area in 1991, HMP's quality assurance deficiency was of particular concern to HCFA officials because of the high risk that HMP's financial arrangements transfer to its affiliated providers. HCFA will have authority to limit such transfers of risk effective January 1992, but the implementing regulations may not be issued by that time. Consequently, unless HCFA places a higher priority on completing these regulations, HCFA will be unlikely to be able to use its authority to end abuses until sometime after January 1992.

Reimbursement at a predetermined payment rate for each enrollee provides a strong incentive for HMOs to be cost conscious. This incentive can also result in HMOs' underserving enrollees. As a check on this incentive for underservice, federal standards require HMOs to have an internal quality assurance system capable of detecting and correcting patterns of inadequate care furnished by individual physicians. In 1989 and again in 1990, HCFA found that HMP did not collect enough ambulatory care data to systematically identify physicians with patterns of underutilization of services.

Both HMP and the Florida PRO have found quality of care problems that demonstrate why it is important that HMP have a quality assurance program that meets federal standards. HMP's quality assurance program, HMP officials said, has identified a number of quality-related problems for which it has taken adverse action against providers. Between mid-1987, when HMP began operating, and May 1991, HMP terminated 27 affiliated medical centers for quality-related reasons and denied 12 physicians the credentials needed to continue serving HMP enrollees.

Between November 1987 and March 1991, the PRO's routine review of HMP's ambulatory care identified 35 physicians whom the PRO decided to place under intensified review because of patterns of underservice to Medicare enrollees.¹⁸ These patterns included failure to order appropriate diagnostic tests and failure to follow up on abnormal test results. As of June 1991, the PRO planned to place five more HMP physicians under intensified review because of similar patterns of underservice. However, PRO officials report that their ability to systematically review and identify HMP physicians who underserve Medicare enrollees would

¹⁸According to Humana officials, 10 of these 35 physicians are no longer serving HMP enrollees.

have been enhanced had the PRO had adequate data on the ambulatory care provided by HMP's physicians.

HCFA's concern over HMP's lack of adequate quality assurance data was heightened by HMP's financial arrangements with affiliated providers, which gives them an incentive to underserve enrollees.¹⁹ Under HMP's usual Medicare contract with affiliated providers, the affiliates bear substantial financial risk for two categories of cost:²⁰

- 50 percent of any losses incurred in providing hospital, outpatient surgery, nursing facility, and home health services to its enrollees and²¹
- 100 percent of losses incurred in providing primary care, specialty physician care, and outpatient prescription drugs.

In its 1989 monitoring report, HCFA expressed concern that the level of risk borne by affiliated providers could give them excessively strong incentives to underserve beneficiaries. This arrangement made it imperative, HCFA concluded, that HMP develop a system to routinely monitor primary and specialty ambulatory care services.

Based on its 1991 monitoring site visit to HMP and review of information submitted by HMP as part of a corrective action plan, HCFA believes that the HMO has developed and begun implementing such systems. To help assure the systems' adequacy, HCFA has asked HMP to submit quarterly reports of data produced by the systems for HCFA's review.

With regard to HMO risk-sharing arrangements, the Omnibus Budget Reconciliation Act of 1990 gave the Secretary of HHS authority, beginning January 1, 1992, to limit those arrangements found to provide excessive incentives to underserve. As of November 1991, HHS was still drafting the regulations and had scheduled them for release for comment in early 1992.

¹⁹Appendix I discusses in more detail the financial arrangements between HMP and its affiliates and the general concerns raised by risk-sharing agreements.

²⁰As of March 1991, affiliated providers bearing substantial risk served 85 percent of HMP's Medicare enrollees in the Miami and Tampa markets.

²¹Under a stop-loss provision, HMP relieves the affiliated provider of any responsibility for costs of any single hospitalization exceeding \$20,000.

Lack of Regulations, Policies, and Standards Impedes Resolution of Problems

HCFA's lack of regulations and policies covering the use of its authority to impose sanctions on noncompliant HMOs was the principal reason HCFA cited for not imposing sanctions on HMP. While HCFA has authority to impose intermediate sanctions, it has been reluctant to use this authority in the absence of implementing regulations. In addition, HCFA has found that it cannot enforce requirements that HMOs pay claims accurately because it lacks published standards for claims payment accuracy.

HCFA's Existing Sanction Authority Remains Unused

HCFA has had authority to suspend enrollment in HMOs in a number of circumstances since 1987.²² The 1987 Omnibus Budget Reconciliation Act gave the Secretary of HHS the authority to impose civil monetary penalties, suspend the enrollment of Medicare beneficiaries, and suspend payments for newly enrolled beneficiaries when an HMO commits certain acts, among which are

- failure to pay provider bills in a timely fashion,
- substantial failure to provide medically necessary items and services required under the contract that adversely affect an individual, and
- misrepresentation or falsification of information provided to the Secretary or to other individuals and entities.

HCFA's intermediate sanction authority remains unused because HCFA has not issued regulations or developed policies governing its use. Although the Congress granted this authority in December 1987, HHS has not issued implementing regulations and HCFA officials have been reluctant to use the authority without regulations.²³ The draft regulations have moved more slowly than anticipated, HCFA officials said, because of staffing shortages, the development of higher priority regulations, and the fact that these regulations were a joint project between HCFA and the HHS Office of Inspector General.

HCFA's use of its intermediate sanction authority to correct HMO deficiencies may also continue to be impeded because HCFA does not have policies for determining the circumstances under which it should impose such sanctions on noncompliant HMOs. In the case of HMP, this lack of

²²The Omnibus Reconciliation Act of 1986 gave the Secretary authority to suspend enrollment if an HMO with a Medicare risk contract violated the requirement that at least one-half of its total enrollment be people not entitled to Medicare or Medicaid. However, this has not been an issue at HMP.

²³These regulations were published in draft form for comment in July 1991.

policy was a cause of conflict between the Office of Prepaid Health Care and HCFA's region IV, which shared responsibility for monitoring HMP.

Region IV believed that the Office of Prepaid Health Care should develop policies permitting HCFA to initiate an intermediate sanction against the HMO because of its failure to correct violations. In October 1989, region IV issued a warning letter to HMP, pointing out that serious deficiencies in the areas of claims payment and marketing, found in the February 1989 monitoring site visit, remained unresolved. It concluded that HMP's failure to correct these deficiencies in areas of high potential impact on Medicare beneficiaries "... raises serious questions about the plan's ability to satisfactorily administer a Medicare [HMO] contract." Region IV threatened to recommend sanctions, including a temporary suspension of enrollment, unless HMP took swift action to correct these deficiencies.

Shortly after it sent this letter to HMP, in November 1989, region IV recommended that the Office of Prepaid Health Care develop policies for suspending enrollment or imposing monetary penalties on HMOs, such as HMP, with persistent marketing, claims payment, or quality-of-care problems. The region argued that the existence of penalty options would give HMOs needed incentives to improve performance. Officials of the Office of Prepaid Health Care, however, said that they did not attempt to impose a sanction against HMP because of the lack of regulations. Further, they did not develop the policies recommended by region IV.

HCFA still lacks policies to provide staff guidance on the circumstances under which it will pursue intermediate sanctions against HMOs. Absent such policies, uncertainty about when sanction authority should be used may again result in inaction against HMOs with deficiencies.²⁴ HCFA officials have established an internal work group, they said, to develop recommendations regarding such policies.

²⁴Partly as a result of the Humana experience, HCFA has acted to strengthen oversight of the HMO risk-contracting program and make it easier to resolve conflicts between regional and central office entities monitoring HMOs. In March 1991, HCFA abolished the Office of Prepaid Health Care, which reported directly to the HCFA Administrator. In its place, HCFA created a new Office of Prepaid Health Care Operations and Oversight, which reports, as do the regional offices, to the Office of the Associate Administrator for Operations. This change places the responsibility for oversight and sanction authority under one HCFA office.

Absence of Standards Impedes Enforcement of Requirements to Pay Claims Accurately

In 1991, HCFA concluded that it could not consider an HMO's inappropriate denial of claims or other accuracy deficiencies in claims payment as violations of Medicare standards. HCFA found a significant level of inappropriate claims denials by HMP's affiliated providers during its 1991 HMP site visit. Though in earlier years HCFA had cited HMP for inaccurate claims payment determinations, HCFA concluded that it could not do so again because it had not developed and published standards defining the maximum percentage of inaccurate payments or inappropriate denials it will tolerate.

HCFA officials believe that HCFA's inability to enforce requirements for HMOs to pay their claims accurately as well as in a timely manner is a serious problem. They had formed a work group, they said, tasked with developing standards as well as more generally examining enforcement issues.

Future Problems Can Be Minimized by Expanding Sanction Authority

As we reported in 1988, HCFA could benefit from broader sanction authority than that specified in the Omnibus Budget Reconciliation Act of 1987. The existing statute would not permit HCFA to impose an intermediate sanction in every circumstance under which an HMO might be in violation of requirements.

Given these circumstances, in our 1988 report we recommended that the Congress consider giving HCFA broader authority so that it could more easily apply intermediate sanctions.²⁵ Specifically, we recommended that HCFA be given greater discretion to suspend Medicare enrollments in HMOs that for whatever reason, fail to respond to notices of violation in a timely manner or have recurring compliance problems. Our work has shown that noncompliance in any area can have significant adverse effects on beneficiaries by increasing their out-of-pocket costs or reducing their access to and quality of care. Broadening HCFA's ability to obtain prompt resolution of an HMO's deficiencies could reduce beneficiary risks. Further, Medicare beneficiaries who enroll in an HMO have a right to expect that the HMO is meeting the minimum Medicare standards required by its federal contract.

²⁵Medicare (GAO/HRD-88-73), p. 59.

Conclusions

The HMP case illustrates, as did our earlier work, that HCFA has not been effective in achieving prompt corrective actions from some noncompliant HMOs. Continuing problems in this area raise questions concerning HCFA's willingness and ability to enforce Medicare requirements when HMOs are not responsive to its requests for corrective actions.

HCFA has not taken all actions it could to deal decisively with noncompliant HMOs. Specifically, we believe HCFA should adopt specific policies for determining under what circumstances and when it should impose intermediate sanctions against noncompliant HMOs. Establishment of policies would help ensure that HCFA makes the best use of its existing authority by providing explicit guidance as to the course of action it should choose. The absence of such policies, which was a factor in delaying decisive action, has resulted in conflict within HCFA regarding what actions should be taken against HMP.

In addition, the absence of standards for claims payment accuracy has caused HCFA officials to arrive at this conclusion: they cannot cite contracting HMOs as out of compliance with Medicare requirements for inappropriately denying claims. Because of the potential risks to beneficiaries from such practices as inappropriately denying payment for emergency or urgently needed care, we believe that HCFA should develop and publish standards enabling it to enforce accuracy requirements.

In addition, we believe broadening HCFA's sanction authority along the lines that we recommended in our 1988 report could help avert future problems by making any violations by an HMO subject to intermediate sanctions. With broader sanction authority, HCFA would also be more accountable if it chose not to sanction an HMO.

Recommendation to the Secretary of Health and Human Services

- We recommend that the Secretary direct the Administrator of HCFA to
- establish policies that specify the circumstances and timing regarding when it will impose sanctions on HMOs with Medicare risk contracts that are violating Medicare requirements and
 - develop and publish standards that will enable HCFA to require contracting HMOs to pay accurately as well as in a timely manner.

HHS and Humana Comments and Our Evaluation

HHS commented on a draft of our report in a letter dated October 11, 1991 (see app. II). HHS agreed with our first recommendation,²⁶ noting that following the creation of the new Office of Prepaid Health Care Operations, it had established a joint central office/regional office work group responsible for developing such policies. HHS also indicated that HCFA was interested in intermediate sanctions as a means of ensuring HMO compliance with requirements and was examining the need to expand its existing sanction authority. However, HHS generally objected to the way we characterized HCFA's actions in response to HMP's long period of noncompliance.

In particular, HHS objected to our use of the terms compliance and non-compliance in relation to the findings of HCFA's site visit reports to Humana. Specifically, HHS stated that noncompliance can be determined only by an investigation conducted under the authority of title 13 of the Public Health Service Act, which governs federal qualification of HMOs.²⁷ According to HHS, although HCFA may find during a site visit that a requirement is "not met" by an HMO, the HMO nevertheless cannot be said to be out of compliance with that requirement. Humana expressed similar concerns in its review of our draft report.

We modified our report to use the term violation in place of noncompliance where we cite HCFA findings. We believe that our use of the term noncompliance in other places is appropriate. Our characterization that HMP was out of compliance where HCFA found HMP to be in violation of requirements is well within the commonly accepted usage of the word. We have added a footnote on page 1 to clarify our use of the term noncompliance.

Humana said that our use of the term Humana in our draft report to refer to HMP, its Florida Medicare HMO contractor, was inappropriate. Humana pointed out that other Humana affiliates, which were not addressed in this report, held Medicare contracts in other areas of the country. In addition, Humana argued that because HMP is divided into four market areas and HCFA, in some cases, found that deficiencies were not common to all areas, we should refer to specific market areas. We agree that use of the term Humana when referring specifically to HMP

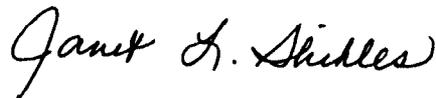
²⁶HHS was unable to comment on our second recommendation because it is based on information obtained after HHS's comments. However, we discussed this recommendation with HCFA officials, and they generally agreed with it.

²⁷An HMO must be federally qualified to hold a Medicare risk contract. Additional standards for HMOs with such contracts are found in title 18 of the Social Security Act.

could be confusing and have modified our report accordingly. However, HCFA's 1989 and 1990 site visit reports treat HMP as a single entity. In 1991, HCFA plans to issue a separate site visit report for each market area. Because HMP has one Medicare contract covering its four Florida market areas, we continue to refer to it as a single entity.

HHS and Humana also made several detailed comments relating to specific portions of our draft report. We considered these and modified our report where appropriate.

We are sending copies of this report to the Director, Office of Management and Budget; the Secretary of HHS; the HHS Inspector General; and other interested congressional committees. We will also make copies available to other interested parties on request. Please call me on (202) 275-5141 if you or your staff have any questions about this report. Other major contributors are listed in appendix III.



Janet L. Shikles
Director, Health Financing
and Policy Issues

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Abbreviations

GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
HMP	Humana Medical Plan
PRO	peer review organization

Risk-Sharing Arrangements Could Lead to Underserving Beneficiaries

HMP's standard full-risk contract transfers much of HMP's financial risk to its affiliated providers. This high level of risk could give such providers excessively strong incentives to underserve Medicare beneficiaries, a concern with which HCFA concurs. This risk-induced incentive to underserve Medicare enrollees is compounded by the relatively small enrollments over which most of these centers spread their risk. Furthermore, many affiliates have memberships that are predominately Medicare, increasing their risks from Medicare losses.

Under HMP's standard full-risk contract, an affiliate is allotted a predetermined monthly payment for each Medicare enrollee who selects that affiliate for primary care services. HMP divides the allotment between (1) a part A fund to cover hospital, outpatient surgery, nursing facility, and home health services and (2) a part B fund to cover primary care, specialty physicians, and outpatient prescription drugs. The affiliate bears the risk or reaps the benefit for 100 percent of any deficit or surplus incurred in the part B fund and 50 percent of any deficit or surplus incurred in the part A fund. Mitigating this risk to some extent, the full-risk contract contains a stop-loss provision, under which HMP assumes 100 percent of the costs exceeding \$20,000 for any single hospitalization.¹ As of March 1991, 204 of the 240 affiliated providers in the Miami and Tampa markets had full-risk contracts with HMP. These providers served 85 percent of HMP's Medicare enrollees in these markets.

HCFA has recognized the heightened risk for underservice to beneficiaries inherent in these financial arrangements. In its 1989 site visit report on HMP, HCFA noted that "the financial relationship between HMP and the affiliated centers places obvious incentives on the part of the providers/owners to undertreat or under-refer." HCFA concluded that this arrangement made it imperative that HMP develop systems "for the routine monitoring of primary and specialty ambulatory care services. . . ."

Shifting financial risk for services to affiliated physicians poses a significant potential threat to quality of care in HMOs, as we reported in 1988.² An affiliated physician can be placed in a compromising position when treating potentially expensive cases. For example, if an affiliated physician must pay for specialty or institutional services out of his or her

¹The stop-loss fund is a pool funded through a contribution for each enrollee made by each affiliate that operates under a full-risk contract. This fund also covers in full the costs of major organ transplants and AIDS cases.

²Medicare: Physician Incentive Payments by Prepaid Health Plans Could Lower Quality of Care (GAO/HRD-89-29, Dec. 1988).

Appendix I
Risk-Sharing Arrangements Could Lead to
Underserving Beneficiaries

own account, the physician has an incentive not to use them because of the potential effect on his or her own financial solvency.

Medicare law addresses these risks of insolvency and reductions in quality of care, but in a limited way. To guard against these risks, HMOs must meet certain membership enrollment standards to qualify for Medicare risk contracts. Such HMOs must enroll at least 5,000 members (1,500 in rural areas) and limit the number of Medicare and Medicaid enrollees to no more than 50 percent of the total enrollment. However, these standards do not apply to an HMO's affiliated providers.

In the Miami and Tampa markets, all of HMP's 204 affiliated providers that serve Medicare enrollees under full-risk contracts had fewer than 5,000 enrollees; most had total enrollments of fewer than 2,000 (see table I.1). Furthermore, 113 of the 204 affiliates had Medicare enrollments that exceeded 50 percent of total enrollment.

Table I.1: Medicare Enrollees Under Full-Risk Contracts in HMP-Affiliated Providers Serving the Miami and Tampa Markets (Mar. 1991)

Provider's total enrollment	Number of providers whose Medicare enrollment was		Total
	More than 50 percent	50 percent or less	
5,000 or more	0	0	0
4,000 - 4,999	1	1	2
3,000 - 3,999	6	2	8
2,000 - 2,999	14	7	21
1,000 - 1,999	47	28	75
Less than 1,000	45	53	98
Total	113	91	204

Transferring a high proportion of risk from an HMO to affiliated providers creates medical care entities that function much like independent HMOs, but have no minimum enrollment standards, as we noted in a 1986 report.³ In a network HMO such as HMP, beneficiaries are spread out among affiliated providers, which may bear a substantial proportion of the risk of patient care and may have an enrollment base too small to safely absorb this risk. Although we recommended that the Secretary of HHS issue regulations specifying standards for financial solvency and enrollment that an HMO must require of subcontractors bearing substantial risk, HCFA does not plan to do this.

³Medicare: Issues Raised by Florida Health Maintenance Organization Demonstrations (GAO/HRD-86-97, July 1986).

Comments From the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

OCT 11 1991

Ms. Janet L. Shikles
Director, Health Financing
and Policy Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Ms. Shikles:

Enclosed are the Department's comments on your draft report, "Medicare: HCFA Needs to Take Stronger Actions Against Noncompliant HMOs." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely yours,

Richard P. Kusserow
Inspector General

Enclosure

Comments of the Department of Health and Human Services
on the General Accounting Office Draft Report
"Medicare: HCFA Needs to Take Stronger
Actions Against Noncompliant HMOs"

Overview

At the request of the Chairman of the Subcommittee on Health, House Committee on Ways and Means, GAO assessed Federal oversight of the Humana Medical Plan, Inc. in Florida. Humana is Medicare's largest health maintenance organization (HMO) contractor. Specifically, the Chairman asked GAO to ascertain whether the Health Care Financing Administration (HCFA) had identified problems alleged by the press and whether HCFA's actions to resolve problems at Humana were prompt and effective.

According to GAO, although HCFA sought to get Humana to resolve its deficiencies by repeated requests for compliance, as of July 1991, Humana remained out of compliance in three of four problem areas; i.e., marketing, claims payment, and beneficiary appeals. GAO believes HCFA can and should have done more to require that Humana resolve its compliance problems.

GAO Recommendation

The Secretary should direct the Administrator of HCFA to establish policies that specify the circumstances and timing regarding when it will impose sanctions on HMOs with Medicare risk contracts that are out of compliance with Medicare standards.

Department Comment

We agree with this recommendation. As noted in footnote 23 of the draft GAO report, HCFA has established a new Office of Prepaid Health Care Operations and Oversight (OPHCOO). OPHCOO has already established a joint central office/regional office workgroup to develop and recommend an enforcement process for the imposition of available intermediate sanctions and/or civil monetary penalties against contracting HMOs failing to comply with Medicare requirements. This workgroup is charged with identifying the enforcement tools available for specific kinds of problems, establishing criteria for their use, and recommending appropriate time frames for taking such actions. It is expected that the workgroup's recommendations will be completed by January 1992.

Other Comments

Changes Attributable to the Humana Experience: the Creation of OPHCOO. The OPHCOO as a component in HCFA's operations block, reports to the same line management as the HCFA regional offices (ROs). The new office was created not only to improve the coordination and communication between HCFA central office

and the ROs, but also to strengthen oversight of the Medicare HMO risk contracting program. OPHCOO was created in part because, as a result of the manner in which the Humana situation evolved, HCFA recognized the need for an improved system of HMO oversight.

One of the first actions taken since the creation of OPHCOO was the establishment of the workgroup (discussed in response to GAO's specific recommendation), as well as a group charged with examining the appropriate responsibilities of central and regional offices in HMO oversight. We expect the groups to complete their reviews by January 1, 1992.

HCFA's Willingness to Enforce Medicare Contracting Requirements. We wish to clarify GAO's questions regarding HCFA's willingness and ability to enforce Medicare requirements when HMOs are not responsive to HCFA requests for corrective actions. There should be no misunderstanding that HCFA recognizes its statutory responsibility to protect Medicare beneficiaries enrolled in HMOs, and that HCFA is more than willing to fulfill those responsibilities within its available resources. In our opinion, the draft report gives a misleading impression of HCFA inaction. First, the report repeatedly chides HCFA for its apparent inability to publish promptly a regulation implementing the sanction authorities made available under the Omnibus Budget Reconciliation Act (OBRA) of 1987. Second, we are chided for our reluctance to use the statutory sanction authorities in the absence of implementing regulations.

A total of five successive pieces of legislation--OBRA '86, OBRA '87, the Medicare and Medicaid Patient Protection Act of 1987, the Medicare Catastrophic Coverage Act of 1988, and OBRA '89--either added to or broadened the intermediate sanction/civil monetary penalty authorities made available to the Secretary. Consequently, on four successive occasions HCFA and the Office of the Inspector General (OIG) were required to withdraw and revise the proposed implementing regulations. Fortunately, OBRA '90 did not affect the previous changes, and as a result a proposed rule was published in the *Federal Register* on July 22, 1991. The comment period closed September 20. HCFA and the OIG, which jointly authored the proposed rule, plan to publish a final rule as expeditiously as possible.

On the second point, not using available sanctions, it should be made clear that our reluctance to use the sanction authority was based on the Department's determination that, pending the publication of a final rule, HCFA should limit its use of the intermediate sanction authorities to cases in which there could be no doubt as to whether an HMO committed one of the violations identified in the statutory language. For example, an HMO may be sanctioned for allowing its Medicare/Medicaid enrollment to exceed 50 percent of its total enrollment. Exceeding the enrollment limit is a clear-cut violation of a requirement that does not require a subjective judgment to determine that a violation has occurred.

However, sanctions are also applicable in situations in which a subjective determination must be made: for example, judgment is required in determining whether an HMO "fails substantially to provide medically necessary items and services...if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual" (section 1876(i)(6)(A)(i) of the Social Security Act, emphasis added); or in determining whether there has been misrepresentation or falsification of information furnished to HCFA. If HCFA were to attempt to impose intermediate sanctions in such cases, HCFA could be open to legal challenge and could create an undesirable precedent if a court were to accept jurisdiction over the challenge. Consequently, we chose not to impose sanctions against Humana.

Additional Sanction Authority. HCFA is very interested in the availability of sanctions, other than contract termination, for ensuring HMO compliance with Medicare contract requirements and is examining the need to expand its current sanction authority.

Alternatives to Sanctions. It should be pointed out that HCFA has employed other available administrative procedures to secure the cooperation of HMOs with problems that have not been resolved in a timely manner. Specifically in the case of Humana, at the time HCFA announced its intention to conduct an investigation of Humana's marketing practices, HCFA also advised Humana that, until the investigation was completed, HCFA would not process any new Medicare applications from the HMO, nor would we permit any expansions of the service areas of any current Humana contract. This proved to be a very effective tool in getting the organization's attention and cooperation. While it did take a year for acceptable corrective action to be approved and implemented, the length of time was a function of the size and unique organizational structure of Humana, and reflected the need for HCFA to coordinate such an effort across three regional offices and five States.

The suspension of further Medicare enrollment through expansion of current contracts or the addition of new contracts proved to be such a successful tool in rectifying the problems with Humana that HCFA has recently employed the same tactic with another large for-profit HMO that has been also put under investigation for potential marketing abuses. The tactic has been proven to be just as effective as in Humana's case in getting the organization's attention and cooperation.

The Purpose of HCFA Monitoring Visits. The purpose of HCFA's on-site monitoring visits to contracting HMOs is not primarily to determine whether any compliance enforcement action is necessary, or whether a contract termination is in order. Rather, in the majority of cases, the findings are used to improve the Medicare contracting operations of organizations that have been reviewed--in a manner similar to HCFA's contractor performance evaluation program for fee-for-service Medicare carriers and intermediaries.

GAO's Position on Physician Incentives. The body of research on the effect of different types of physician incentive plans is inconclusive with respect to whether, categorically,

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Now on pp. 12 and 13.

a specific type of incentive arrangement is known to lead to under-service or substandard care. The GAO report mentions the authority given to HCFA to "limit" physician incentive arrangements as of January 1, 1992 (pages 18 and 21). The report should clarify that the law (section 1876(i)(8) of the Social Security Act) prohibits direct or indirect payments to a physician or physician group to reduce or limit services to a specific individual. The law does not prohibit an incentive arrangement that "places a physician or physician group at substantial financial risk (as determined by the Secretary) for services not provided by the physician or physician group." Instead, the law requires the organization to have acceptable stop-loss protection (evaluated in terms of the number of physicians or groups placed at risk and the number of enrollees they serve), and the organization must conduct member satisfaction surveys to determine whether there are problems with access to health care.

GAO's analysis in Appendix I is the type of analysis that HCFA would undertake to determine the acceptability of Humana's risk arrangements, but the analysis provided by GAO should not be construed to definitively show that Humana's risk arrangements would be prohibited. For example, the capitation payments for Part B services are not specified; and the enrollment figures are discussed in terms of exceeding 50 percent Medicare. An important issue in evaluating risk arrangements is total enrollment (Medicare or otherwise) for which a physician or group is placed at risk.

The Physician Incentive Regulation is one of HCFA's highest priorities. Congress enacted the provisions in OBRA 90. In the short period of 9 months, we have developed policies for a draft regulation that are currently under HCFA and departmental review. We expect a notice of proposed rule-making (NPRM) to be published prior to the January 1992 effective date. Because of the complex nature of the regulation and its broad impact on the HMO industry, we believe it is preferable to issue a final regulation only after providing sufficient opportunity for public comment.

Problems with Terminology. Although the GAO report (footnote 13) notes an investigation conducted under provisions of Title XIII of the Public Health Service Act (i.e., the HMO Act), the report does not recognize that the terms *investigation* and *compliance* are terms with very specific meanings, as explained below in the first comment of our "Technical Comments" dealing with Page 2 of the draft report.

Recent HCFA Findings Regarding Humana's Performance. As will be discussed more fully in the "Technical Comments," HCFA, on October 2, finalized a comprehensive report on the 1991 monitoring visit to Humana's Miami market office and is finalizing comprehensive reports on site visits to each of Humana's three other market offices. HCFA expects to release the remaining three reports shortly. The reports find that each market office meets requirements for quality assurance and marketing. Each market office except Miami meets the requirement for claims processing. While Humana-Miami had taken corrective action, which was expected to resolve its claims

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processing deficiencies, it did not meet the requirement for claims processing at the time of the site visit.

The reports will find that each market office, with the possible exception of Tampa, is experiencing significant deficiencies with respect to its handling of grievances and appeals.

In addition, on August 7, we closed the investigation of marketing practices for the four market offices under the Humana-Florida contract initiated in January 1990, based on our conclusion that Humana-Florida had made appropriate changes in this area and currently meets the Federal requirements.

Major Contributors to This Report

**Human Resources
Division,
Washington, D.C.**

Edwin P. Stropko, Assistant Director, (202) 426-0843
Peter E. Schmidt, Assignment Manager
Richard N. Neuman, Senior Evaluator
Hannah F. Fein, Editor

**Atlanta Regional
Office**

Ira B. Spears, Regional Management Representative
Jacqueline Harpp, Evaluator-in-Charge
Cheri Y. White, Evaluator

Related GAO Products

Medicare: PRO Review Does Not Assure Quality of Care Provided by Risk HMOs (GAO/HRD-91-48, Mar. 1991).

Medicare: Experience Shows Ways to Improve Oversight of Health Maintenance Organizations (GAO/HRD-88-73, Aug. 1988).

Medicare: Issues Concerning the HealthChoice Demonstration Project (GAO/HRD-88-69, July 1988).

Medicare: Issues Raised by Florida Health Maintenance Organization Demonstrations (GAO/HRD-96-97, July 1986).

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